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Physicians dedicated to the health of America

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* high priority this week
5
- 5/31
Wait to July

May 14, 1997

Chris Jennings
Special Assistant to the President
for Health Policy Development
The white House
Washington, DC 20500

Dear Chris:

Enclosed is a good background document on the PATH Audits. I understand that Marilyn Yager has spoken to you about this. It may be a good idea for all of us to get together (Marilyn, AAMC, AMA and you) as early as next week. I would be glad to provide additional information as you see fit.

As you know, this is a real hot button issue with the medical community. Without some changes in the IG's audit protocols, we may be forced to pursue litigation.

Sincerely,

Richard A. Deem

Marilyn Yager
(615) 322-2151

Meeting around July 1st
- Schedule of Sally Katzen (OMB), Nancy-Ann, Chris, Rich Deem (or AMA), AAHE Marilyn Yager (?) Barbara Woolley on HHS Regulations (Schedule last wk of June)

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February 14, 1997

The Honorable Donna E. Shalala
Secretary of Health and Human Services
The Humphrey Building
200 Independence Ave., SW
Washington, DC 20201

Dear Secretary Shalala:

During the past several months the American Medical Association (AMA) has become increasingly concerned about the implementation of HHS Office of Inspector General's (OIG) audit program known as the Physicians at Teaching Hospitals (PATH) Initiative.

The AMA recognizes and supports the right and the obligation of the OIG to conduct audits to assure the integrity of the Medicare program. And we share the desire to rid our entire health care system of fraud and abuse. Toward this end, the AMA has worked closely and effectively with the FBI and its Health Care Fraud Task Force to provide information and resources to assist in fraud enforcement.

We are, however, wary of government enforcement efforts that go too far. We believe strongly that PATH audits must be conducted in a manner consistent with the law in effect at the time the audited claims were filed. The crux of our concern with the PATH program is that in some cases the OIG may be applying standards and regulations that did not become effective until August 1, 1995 and July 1, 1996 to billing activity that occurred well before these dates.

By applying new regulations to claims filed well before the regulations went into effect, the OIG threatens the integrity of the Medicare program and calls into question the authority of HHS to interpret the law. Providers cannot be assured of the proper course of conduct if they rely on HHS interpretations and are later judged under a different standard. Not only is this retroactive application of regulations grossly unfair, it threatens to cripple our nation's medical schools, teaching hospitals and faculty practice plans.

In addition, the AMA objects to the approach that the OIG is taking that a teaching physician's lack of adequate documentation for Medicare billing purposes is tantamount to filing a fraudulent claim. The implication is that physicians did not actually provide the services for which claims were filed. It is our understanding that in the majority of the PATH Initiative audits, the billed services were actually provided. The dispute has

been over whether physicians adequately documented their participation, not whether physicians filed false claims. We feel strongly that so long as billed services were actually provided, the Federal False Claims Act should not be used against physicians who abided by documentation requirements that existed at the time the claims were filed.

1. OIG Claims Teaching Physician's Countersignature is Insufficient Documentation

For years, teaching physicians have relied on Intermediary Letter IL-372 and IL-70-2 as the standard for establishing what documentation was required for submitting claims. The language of IL-372 is unequivocal. Although IL-372 is criticized because it was never subject to public notice and comment, the letter provides the only guidance of what was required for teaching physician documentation. IL-372 provides as follows:

> Performance of the activities . . . must be demonstrated, in part, by notes and orders in the patient's records that are either written by **or countersigned** by the supervising physician.

The language of IL-70-2 is equally as clear. A teaching physician's countersignature is recognized as sufficient documentation at least twice. This letter states:

> If the physician **countersigned** the entries in the record pertaining to the patient's history and the record of examinations and tests, it would be presumed the physician personally examined the patient and determined the course of treatment to be followed. Frequent reviews of the patient's progress by the physician would be established by the appearance in the record at the physician's signed notes **and/or countersignature** to notes with sufficient regularity that it could be reasonably concluded that he was personally responsible for the patient's care.

Thus, these letters clearly exhibit HHS' intent that a countersignature represented adequate documentation of involvement by the teaching physician. Unfortunately, the OIG has seen fit to defy this intent by decreeing unilaterally that a teaching physician's countersignature is insufficient. For the OIG to be satisfied, there must have been additional evidence of the teaching physician's involvement either through a specific reference in the resident's note or in an independent document.

Nothing in IL 372 or IL-70-2 indicated that HCFA required anything more than a countersignature. The OIG has in effect rewritten HCFA policy so that the standard for reviewing the level of documentation is the new teaching physician rule, which only became effective July 1, 1996. It is completely unreasonable and a direct usurpation of HCFA's authority for the OIG to apply a July 1, 1996 standard to established HHS policy, which ruled before this date.

2. The OIG's Retroactive Application of the Physical Presence Requirement

The AMA has a similar complaint with the OIG's recreation of the standard for ensuring the appropriate level of a teaching physician's physical presence. The OIG in carrying out its PATH audits claims to be using criteria contained in HCFA's Intermediary Letter 372 (IL-372) as the standard for determining whether a teaching physician was "physically present" for purposes of billing for Medicare services. What the OIG is really doing is taking the new teaching physician standard which did not become effective until July 1, 1996 and applying it to claims filed years before. Prior to July 1, 1996, the general rule for teaching physician involvement was as follows:

> Payment on the basis of the physician fee schedule applies to the professional services furnished to a beneficiary by the attending physician when the attending physician furnishes personal and identifiable *direction* to interns or residents who are participating in the care of the patient.

Only in the case of major surgical procedures and other complex situations was the attending physician required to "personally supervise the residents and interns."

Unfortunately, the language of IL-372 (adopted in 1969) was inexact and confusing. Even HCFA recognized this problem when it said in the preamble to the new teaching physician rule:

> . . . the Intermediary Letter 372 policy left it to individual carriers to determine coverage of the [teaching physician] services based on customary practices in the area . . .

Not only was IL-372 not clear on the standard to be used, HCFA's own proposed rule on the subject only required that the teaching physician be "immediately available" rather than "physically present."

We could continue to cite additional evidence establishing that HCFA had no clear and articulate standard for teaching physicians before the July 1, 1996 new rule. Suffice it to say, however, that using this new rule to measure billing practices that occurred prior to July 1, 1996 is patently unfair and may be open to legal challenges.

3. Documentation of Evaluation and Management Services

As you know, when a physician visits a patient in a clinic or hospital, different reportable levels of service may be appropriate for that visit or consultation, based on the content of the service provided and/or the amount of time the physician spends with the patient. These services are commonly known as evaluation and management

services (E/M). From January 1, 1990 until August 1, 1995, HCFA had promulgated no uniform documentation standards to apply to billing for E/M services. On January 1, 1992, HCFA implemented an entirely new set of E/M services to conform to the RBRVS requirements. Since these codes were new, were not compatible in content with the previous (i.e. pre-1992) set of E/M codes, and a considerable educational period was anticipated, HCFA actually told carriers that they should not conduct audits on the level of visit services until its own documentation guidelines were completed.

HCFA worked with the AMA and other physician specialty groups to develop visit documentation guidelines before this report was published. These guidelines were available to carriers by November 1994. The carriers were supposed to have held educational seminars on the guidelines during the period November 1994- May 1995. The carriers were then to commence a gradual "phase -in" of the documentation guidelines.

HCFA actually instructed carriers that in their medical review audits, carriers should not use the guidelines until after August 1, 1995. Indeed, HCFA officials stated in meetings that the carriers would not attempt to retroactively enforce the documentation guidelines during the phase-in period. Despite these repeated promises, it is our understanding that the OIG has applied these guidelines to billing practices that occurred prior to August 1, 1995. Not only were physicians not on notice that these guidelines would apply, they were told specifically that they would not apply before August 1, 1995.

4. Credits for Undercoding

The AMA strongly believes that should the OIG during its PATH Initiative discover that teaching physicians have undercoded for a service, the OIG should offset these underpayments to teaching physicians against claims of overcoding.

This letter serves as an overview of our concerns regarding the PATH Initiative. In short, we do not believe that teaching hospitals and other entities which bill for Medicare services should be punished for actions taken when no one was ever put on notice that these actions were impermissible until after the fact.

5. Request for Clarification of the PATH Initiative

In the months ahead we hope to be able to work together to make the PATH Initiative a reasonable and productive effort. The AMA recognizes the OIG's obligation to uncover fraudulent activity. Without some level of reasonableness, however, the current process will continue to be coercive, counterproductive and damaging to the financial stability of some of our nation's finest medical facilities.

We recommend the OIG establish a revised set of principles or parameters for conducting its PATH Initiative. In this manner, those conducting the audits would have a clear understanding of their goals and those undergoing the audits would be assured of a fair and equitable process. We would like to meet with HHS General Counsel, Harriet Raab to discuss clarifying these principles. Margaret Garikes (202-789-7409) of the AMA's Washington office will contact Ms. Raab to schedule a convenient time for such a meeting.

Sincerely,

P. John Seward, M.D.

P. John Seward, MD